DMERC Information Form: IMMUNOSUPPRESSIVE DRUGS

ALL INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER

Certification Type/date INITIAL____/____/____ Revised ____/____/____

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE AND NSC NUMBER
( ) _____HICN _____	( ) _____NSC _____
PLACE OF SERVICE _____ NAME and ADDRESS OF FACILITY if applicable (see reverse):	PT DOB ____/____/____ Sex _____ (M/F)

TRANSPLANT DIAGNOSIS CODES (ICD-9 _CIRCLE APPROPRIATE CODES): V42.1 (HEART) V42.7 (LIVER) V42.0 (KIDNEY)

V42.5 (LUNG) V42.8 (BONE MARROW) V42.8 (OTHER -SPECIFY) (_____)

ANSWERS	ANSWER QUESTIONS 1-5 AND 8-12 FOR IMMUNOSUPPRESSIVE DRUGS (Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)
	Question 6 and 7, reserved for other or future use.
	What are the drug(s) prescribed and the dosage and frequency of administration of each? HCPS MG ES PER DAY 1. _____ _____ _____ 2. _____ _____ _____ 3. _____ _____ _____
Y N	4. Has the pataient had a organ transplant that was covered by Medicare?
Enter Correct Number(s) _____ _____ _____	5. Which organs(s) have been transplanted: (List most recent transplant.) (May enter up to three different organs.) 1-Heart 2-Liver 3-Kidney 4-Bone Marrow 5-Lung 6-Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7-Reserved future use 8-Reserved future use 9-Other
_____	8. Name of facility where transplant was performed?
_____	9. City where facility is located.
_____	10. State where facility is located.
_____	11. On what date was the patient discharged from the hospital following this transplant surgery?
Y N	12. Was there a prior transplant failure of this same organ?

PHYSICIAN NAME, ADDRESS (Printed or Typed)	_____ _____/_____/_____
UPIN:_____	SUPPLIER'S SIGNATURE DATE
TELEPHONE #: ( ) _____	_____ PRINT NAME

Rev. 07/13/2000